EARLY CHILDHOOD LEARNING CENTER
APPLICATION FOR ENROLLMENT

A separate copy of this form must be completed for **each child** applying for enrollment in ESTO Early Childhood Learning Center (ECLC).

Head of Household: _____ DOB: _____

Name of Child: _____ DOB: _____
Do you have custody of the above listed child? ___ Yes ___No ___Shared
If shared, name of one sharing custody: _____

Primary Contact Information (Parent)

Name: _____

Physical address: _____

City: _____ State: _____ Zip:_____ County: _____

Home phone No. _____ Work: _____ Cell: _____

Emergency Contacts (Your child will be released only to parents or these emergency contacts.)

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Family Income

Current Total Household Income: $_____ ___ Weekly ___ Every two weeks
___ Semi-monthly ___Monthly ___ Annually
Sources of Current Income: ___ Employment ___TANF ___ SSI ___ Unemployment ___ Other

If you marked "Other" please explain:
_____

Are you on Childcare Subsidy? ___ Yes ___ No If yes, check which: ___OK ___MO ___KS ___CCDF

I certify that this information is correct to the best of my knowledge. I understand that the information about my income may be reviewed by your State of residence, the Federal Government, independent auditors, or others as necessary for the administration of this program.

Parent or Guardian's Signature _____ Date _____
Are you looking for a child-care or education program so that you can attend school or work? ___Yes ___No

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Do you have concerns about your child's overall health and development? ___ Yes ___ No

If yes, describe concerns: _____

Does your child have a food allergy? ___ Yes ___ No

If yes, to what is the child allergic? _____ Describe any reaction: _____

Is your child on a special diet prescribed by a doctor? ___ Yes ___ No If yes, explain: _____

Please answer the following question only **if your child is 0-12 months old.**

What does your child eat? ___ Breast Milk ___ Formula (Specify brand) _____

___ Milk ___ Other: _____

Medical Information

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Type of Health Insurance: ___ Sooner Care ___ Medicaid ___ Indian ___ Private ___ None ___ Other

Insurance Provider's Name: _____ Dental included? ___Yes ___No

Identify any past or present health conditions your child has had:

___Anemia ___Diabetes ___Asthma ___Hearing problems ___Heart Murmur ___Sickle Cell Disease

___Frequent Constipation ___Vision problems ___Allergies ___Frequent Diarrhea ___Eczema

Will your child need to take medications at school? ___Yes ___No

Release of Liability

I agree to release and save harmless the Eastern Shawnee Tribe of Oklahoma and its agents, employees and representatives, of and from any and all liability of any kind or nature whatsoever in connection with any loss, accidents, injuries, damage or expenses suffered or incurred by me or my family members as the result of participation in any Early Childhood Learning Center (ECLC) programs, including any act or failure to act, intentional or unintentional, by: (1) any agent, employee, or representative of the Eastern Shawnee Tribe of Oklahoma or (2) any person who is not a representative of employee of ECLC or (3) any other volunteer.

Participant's Printed Name: _____

Participant's Signature: _____ Date: _____

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FAMILY INFORMATION

List all those living in the same household **who are supported by the income of the parent/guardian** of the child being enrolled. **List name of Parent/Guardian on first line** with others in the household on the following lines.

LEGAL NAME	DOB	Relation to Child	Gender	Race/Ethnicity	Mark below all that apply
________________________________	_____	________________	__M __F	_____________	__Employed __Part Time __Full Time __Student/Training __Unemployed
________________________________	_____	________________	__M __F	_____________	__Employed __Part Time __Full Time __Student/Training __Unemployed
________________________________	_____	________________	__M __F	_____________	__Employed __Part Time __Full Time __Student/Training __Unemployed
________________________________	_____	________________	__M __F	_____________	__Employed __Part Time __Full Time __Student/Training __Unemployed
________________________________	_____	________________	__M __F	_____________	__Employed __Part Time __Full Time __Student/Training __Unemployed
________________________________	_____	________________	__M __F	_____________	__Employed __Part Time __Full Time __Student/Training __Unemployed
________________________________	_____	________________	__M __F	_____________	__Employed __Part Time __Full Time __Student/Training __Unemployed
________________________________	_____	________________	__M __F	_____________	__Employed __Part Time __Full Time __Student/Training __Unemployed
________________________________	_____	________________	__M __F	_____________	__Employed __Part Time __Full Time __Student/Training __Unemployed
________________________________	_____	________________	__M __F	_____________	__Employed __Part Time __Full Time __Student/Training __Unemployed

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AUTHORIZATIONS AND RELEASES

Parent/Guardian Name: _____

Child's Name:_____ Date of birth:_____

Consent for Health Services

As partial fulfillment of my partnership with the Early Childhood Learning Center (ECLC), I hereby agree that my child:

1) Shall receive all of the health services offered by ECLC including, but not limited to:
    a) Developmental Screening/Observation
    b) Social/Emotional/Behavioral/Mental Health Observations
    c) Vision Screening
    d) Hearing Screening
    e) Height and Weight Assessment
2) Shall brush his/her teeth daily in the Center with an ADA approved fluoride toothpaste and toothbrush provided by ECLC. (If you do **not** want your child to use fluoride toothpaste, check here:) _____ I choose to deny the use of fluoride toothpaste and ask that a non-fluoride toothpaste be used.

Parent Signature _____ Date _____

Authorization for Emergency Treatment

I, the undersigned parent or legal guardian of the child, do hereby authorize any emergency treatment by any physician or dentist licensed by the State of Oklahoma or the State of Missouri and hospital service that may be rendered to said minor under the general, specific or special consent of ECLC, the temporary custodian of the minor.

Parent Signature _____ Date _____

Permission to Transport

I understand that if Child or Parent has a medical emergency while at ECLC, that 911 will be called to transport him/her immediately to the nearest hospital.

Parent Signature _____ Date _____

Permission to Photograph

I give permission to ECLC to use photographs and/or video of me or my family members obtained while participating with ECLC, including posting to social media (Facebook, etc.). (To deny usage of such photos or videos, check here:) _____ I choose **not** to allow photographs and/or videos or social media postings of my family members to be used.

Parent Signature _____ Date _____

Notice of Privacy Policy Receipt

This is to acknowledge that I have receive a copy of ECLC's Privacy Policy, which provides me with information about how ECLC may use and disclose my child's educational, health, and financial information.

Parent Signature _____ Date _____

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PARTICIPATION EXPECTATIONS AGREEMENT

(To be completed with assistance from ECLC staff)

Parent/Guardian Name: _____

____ I have a subsidy from OK or MO or KS or a Native American Tribe for child care services. Subsidy source:

_____

____ I will pay without any subsidy source.

A one-time enrollment fee of $25.00 is charged to cover the cost of setting up an individual account for the child and his/her parents. The $25.00 fee will be applied to the first month's tuition payment when the child(ren) begins attending. However, if the child(ren) do not actually attend, the $25.00 fee will not be refunded. The amount due will be $25.00 **per family** regardless of the number of children enrolled from that family. This contract for payment will be required at the time of enrollment and will state the amount that will be due monthly for each child/family enrolled. The first contract period will begin February 1, 2016 and end July 31, 2016. Each following year, the contract period will begin August 1 and end July 31.

I agree to pay a daily rate of $_____ of which I have a subsidy to pay $_____,

leaving me with a co-pay amount of $_____. Payment is to be made in advance by the first day of each month.

To ensure that your child benefits the most from the ESTO ECLC program, we ask your participation as follows:

- ✓ Understand that you are the most important person to your child's education.
- ✓ Ensure that your child attends every day or that ECLC is notified of any illnesses or absences.
- ✓ Participate with your child in at-home activities designed to promote literacy and learning.
- ✓ Be an active participant in any home visits and parent-teacher conferences.
- ✓ Attend ECLC parent meetings as frequently as possible.
- ✓ Maintain open communication with ECLC staff.
- ✓ Ensure that ECLC has accurate up-to-date emergence contact information.
- ✓ Keep your child's immunizations and well-child examinations up to date and inform ECLC with documentation of updates.
- ✓ If your child does not have a primary care health care provided, you will work with ECLC staff to establish a medical home.
- ✓ Understand that nutritious breakfast, lunch, and snacks are provided during the day. **Due to health regulations, only food that is provided and prepared by ECLC can be served as meals at the center. All outside food is prohibited**.
- ✓ Understand that your child can be removed from the program due to excessive absences.

Parent Signature _____ Date _____